Retirees

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Benefits for Retirees

Benefits available to you in retirement are the focus of this chapter. It is designed to provide useful information to eligible participants in the state insurance program who are considering retirement or who have already retired. For more detailed information on specific programs, please refer to the previous chapters in this guide. If you have questions or need additional information about your insurance, contact EIP through our Web site at www.eip.sc.gov or call 803-734-0678 (Greater Columbia area) or at 888-260-9430 (toll-free outside the Columbia area).

RETIREE INSURANCE ELIGIBILITY REQUIREMENTS

Retirees **from employers that participate in the state insurance program** are eligible for insurance coverage if they meet one or more of these requirements and retire:

- Due to years of service with a participating state insurance employer
- Due to age
- On approved disability through the S.C. Retirement Systems (SCRS)
- On approved Basic Long Term Disability and/or Supplemental Long Term Disability

For more information about state retirement eligibility, call 803-737-6800 (Greater Columbia area) or 800-868-9002 (toll-free outside the Columbia area but within South Carolina) or visit the S.C. Retirement Systems Web site at www.retirement.sc.gov.

To qualify for the retiree group insurance program as either a non-funded or a funded retiree, your last five years of employment must be served consecutively, with an employer that participates in the Employee Insurance Program, and in a full-time, permanent position. Additional service credit for unused sick leave may not be used to qualify for the retiree group insurance program.

Funded and non-funded retirees please note: Whether you are a funded or a non-funded retiree, non-qualified, federal, military, out-of-state employment, sick leave and service with employers that do not participate in the state insurance program does not count toward your 10- or 20-year eligibility requirement.

Funded vs. Non-funded Retiree Insurance Premiums

If you are a state or school district retiree and qualify for funded benefits, the state will contribute to your premiums to the same extent it contributes to the premiums of an active employee. Local subdivisions may or may not pay a portion of the cost of their retirees' group insurance premium. Each one develops its own guidelines for funding retiree insurance premiums.

A local subdivision is a public employer in South Carolina that falls within one of the categories established by Section 1-11-720 of the 1976 S.C. Code of Laws. Local subdivisions include counties, municipalities, regional tourism promotion commissions, county disability and special needs boards, regional councils of government, regional transportation authorities and alcohol and other drug abuse agencies. **If you are a local subdivision employee, contact your benefits office for information about retiree insurance premiums.**

Optional Retirement Program (ORP)

State Optional Retirement Program retirees must follow the same insurance eligibility guidelines as SCRS participants.

Funded Retirees

Funded retirees are those whose employer contributes to their retiree insurance premiums and whose last five years of employment were in a permanent, full-time position with an employer that participates in the state insurance program. They must meet one of these guidelines:

- Employees who are eligible to retire and have 10 or more years of earned S.C. Retirement Systems (SCRS)

service credit with an employer that participates in the state insurance program.
- Employees who leave employment before they are eligible to retire but who have 20 or more years of earned SCRS service credit with an employer that participates in the state insurance program. However, they are not eligible for insurance coverage until they are eligible to receive a retirement check at age 60.
- **An exception:** Employees who left employment before 1990 and who were not of retirement age, but who had 18 years of earned SCRS service credit with an employer that participates in the state insurance program, returned to work with a state-covered group, enrolled in a state health and dental plan, and worked for at least two consecutive years in a full-time, permanent position.

Non-funded Retirees

Non-funded retirees are those who do not quality for funded benefits (see previous rules) and who must pay the full premium, which includes the retiree share plus the state contribution. It may also include an administrative fee. To qualify, a retiree's last five years of employment must have been in a permanent, full-time position with an employer that participates in the state insurance program. Non-funded retirees include:
- Employees who retire at age 55 with at least 25 years of retirement service credit (including at least 10 years of earned service credit with an employer that participates in the state insurance program). You must pay the full insurance premium until you reach age 60 or the date you would have had 28 years of service credit, whichever occurs first. Although sick leave may increase service credit under SCRS, retirees must pay the entire premium until age 60 or until they reach the date they would have had 28 years of service credit if they had continued working. At the end of this period, you will be eligible for funded retiree rates. This rule does not apply to Police Officers Retirement System, General Assembly Retirement System and Judicial Retirement System participants. If you are in one of these groups, contact your benefits office for additional information. If you are retiring from a local subdivision, contact your benefits administrator for premium information.
- Employees who are eligible to retire and have at least five but fewer than 10 years of earned SCRS service credit with a participating state insurance program employer.
- General Assembly members who leave employment before they are eligible to retire and have eight years of General Assembly Retirement System service credit.
- Former municipal and county council members who served on council for at least 12 years and were covered under the state's plans when they left the council. It is up to the county or municipal council to decide whether or not to allow former members to have this coverage.

TERI

A Teacher and Employee Retention Incentive program (TERI) participant is retired for retirement benefit purposes only. For insurance benefits purposes, a program participant is considered an active employee, retaining all other rights and benefits of an active employee. Therefore, if you are a TERI program participant in a permanent, full-time position, your insurance benefits as an active employee continue until your TERI period ends or you become ineligible as an active employee. When your active insurance benefits end, you should file for continuation as a retiree (if eligible) within 31 days of your date of retirement. Your service as a TERI participant in a full-time, permanent position with a participating insurance program employer may be applied toward retiree insurance eligibility.

Any covered subscriber who loses coverage and does not meet any of these rules may still be eligible for continuation coverage under COBRA (see page 14).

HOW TO ENROLL

If you are an eligible retiree, you must enroll by filing a Retiree Notice of Election (NOE) form within 31 days of:
- Your retirement date or
- The end of your TERI period or
- Approval for disability retirement or Long Term Disability benefits or
- A special eligibility situation.

Coverage is not automatic. You may enroll yourself and any eligible dependents. Those enrolling who have had a break in health coverage for more than 62 days will be subject to pre-existing condition exclusions for 12 months.

If you and/or your dependents are **not covered by a state health plan** at the time of your retirement, you may enroll within 31 days of:
- Your retirement date or
- The end of your TERI period or
- A special eligibility situation.

You will be subject to pre-existing limitations for 12 months. Proof of creditable coverage may be used to reduce a pre-existing condition limitation period, if any break in coverage did not exceed 62 days.

Late Entrant

If you and/or your dependents do not enroll within 31 days of retirement, disability approval or a special eligibility situation, you may enroll as a late entrant during an open enrollment period held every odd-numbered year (e.g., October 2007). Your coverage will take effect on the following January 1 (e.g., January 1, 2008), but, as a late entrant, your coverage will be subject to pre-existing condition limitations for 18 months. Proof of creditable coverage may be used to reduce a pre-existing limitation period, if any break in coverage did not exceed 62 days.

YOUR HEALTH PLAN CHOICES AS A RETIREE

Not Eligible for Medicare

If you and your covered dependents are not eligible for Medicare, you may be covered under one of these plans:
- The SHP Savings Plan (You may contribute to an HSA, but not through MoneyPlu$.)
- The SHP Standard Plan
- An HMO offered in the county where you live (See page 50 for counties where each HMO is available.)
- The TRICARE Supplement, if eligible

Your health benefits will be the same as if you were an active employee. Refer to the previous chapters of this guide for details.

Eligible for Medicare

If you and/or your covered dependents are eligible for Medicare, you may be covered under one of these plans:
- The SHP Standard Plan
- The SHP Medicare Supplemental Plan
- An HMO offered in the county where you live (See page 50 for counties where each HMO is available.)

This section will provide details on the benefits available to you. Please note that if you are eligible for Medicare, you may not enroll in the TRICARE Supplement or the SHP Savings Plan, and you cannot contribute to the Health Savings Account associated with the Savings Plan.

WHEN YOUR COVERAGE AS A RETIREE BEGINS

If you go directly from active employment into retirement, retiree coverage will begin on your retirement date only if you retire on the first of the month. Otherwise, retiree coverage will begin the first of the month after your retirement date. Meanwhile, your coverage as an active employee, if applicable, remains in effect. If you are enrolling due to a special eligibility situation, your effective date will be either the date of the qualifying event or the first of the month after the qualifying event. If you enroll during open enrollment your coverage will be effective the following January 1.

Retiree Premiums and Premium Payment

State Agency, Higher Education and School District Retirees
Your health, dental, Dental Plus and long term care premiums are deducted from your monthly SCRS retirement check. If the total premiums exceed the amount of your check, EIP will bill you directly for the full amount, or you may request a bank draft. Your first insurance premiums may be due before your retirement has been processed. For that reason, you may be billed for these premiums. All premiums are due on the 10th of the month. If you do not pay this bill, the amount will be deducted, along with other insurance premiums that may come due, from your retirement check.

Local Subdivision Retirees
You pay your health, dental, Dental Plus and long term care premiums directly to your former employer. That employer decides what portion of the premium he will pay. Contact your benefits office for information concerning your insurance premiums at retirement.

For information on adding and covering dependents, your spouse and children, as well as eligibility requirements for dependents, refer to page 11.

Your Insurance Identification Card in Retirement

Keep your identification card if you do not change plans when you retire. You and your covered dependents will not receive new ID cards at retirement if you remain covered under any SHP option, the State Dental Plan and Dental Plus. You will receive a new health identification card if you are changing from an HMO to any SHP option or vice versa and/or if you enroll in the State Dental Plan or Dental Plus for the first time. If your card is lost, stolen or damaged, you may request a new card from EIP or from these plan administrators:

- State Health Plan - BlueCross BlueShield of South Carolina
- HMO - CIGNA HealthCare, BlueChoice HealthPlan or MUSC Options
- Dental Plus - BlueCross BlueShield of South Carolina
- TRICARE Supplement - DEERS for a military I.D. card, ASI for a TRICARE Supplement card

Contact information for these program administrators is on the inside cover of this guide.

The SHP uses your Social Security Number but also includes the letters, "ZCS" in front of the number to identify you as a subscriber to the SHP's Savings Plan, Standard Plan or Medicare Supplemental Plan.

Decreasing Coverage

You may decrease your health and/or dental coverage if a spouse or dependent child becomes ineligible. This may occur because of divorce or separation, a child turns 19 and is no longer a full-time student, a child turns 25, a child marries or a child becomes employed with benefits. If you drop a dependent from your coverage, you must complete an NOE within 31 days of the date he becomes ineligible. If you are enrolled in TRICARE, please remember coverage for a dependent child under the TRICARE Supplement ends at age 21 unless he is a full-time student. If he is a full-time student, it ends at age 23.

WHEN COVERAGE ENDS

Your coverage will end:

- The day after your death
- The date it ends for all employees and retirees
- If you do not pay the required premium when it is due.

Dependent coverage will end:

- The date your coverage ends
- The date dependent coverage is no longer offered
- The last day of the month your dependent is no longer eligible for coverage. If your dependent's coverage ends, he may be eligible for continuation of coverage under COBRA (see page 14).

If you are dropping a dependent from your coverage, you must complete an NOE within 31 days of the date the dependent is no longer eligible for coverage.

Death of a Retiree

If a retiree dies, you, as a surviving family member, should contact EIP to report the death, end the retiree's health coverage and begin survivor coverage (if applicable). See page 14 for more information on survivor coverage.

When You or Your Dependents Become Eligible for Medicare

About Medicare

Medicare includes these parts—*Part A*, *Part B and Part D*. Part A is your hospital insurance. Most people do not pay a premium for Part A because they or their spouse paid Medicare taxes while working. Part A helps cover your inpatient care in hospitals, in critical access hospitals in rural areas and in skilled nursing facilities. It also covers hospice care and some home healthcare. You must meet certain requirements to be eligible for Part A. Contact Medicare for additional information.

Medicare Part B is your medical insurance. Most people do pay a premium through the Social Security Administration for Part B. It helps cover doctors' services and outpatient hospital care. It also covers some medical services that Part A does not cover, such as some of the services of physical and occupational therapists and home healthcare. Part B pays for these covered services and supplies when they are medically necessary.

When you become eligible for Medicare, it is important to be enrolled in Part B if you are covered as a retiree or as a dependent of a retiree. Medicare becomes your primary insurance, and the State Health Plan becomes the secondary payer. If you are not enrolled in Part B, your claims reimbursement will be limited for the Medicare Part B services you receive.

IMPORTANT MEDICARE NOTE:
If you or one of your dependents become eligible for Medicare, you must notify EIP within 31 days of Medicare eligibility. **If you do not notify EIP of your Medicare eligibility, and EIP continues to pay benefits as if it were your primary insurance,** when EIP discovers you are eligible for Medicare, EIP will:

- **Immediately begin paying benefits as if you were enrolled in Medicare.**
- **Seek reimbursement for overpaid claims back to the date you or your dependent(s) became eligible for Medicare.**

Medicare Part D, the prescription drug plan, became effective January 1, 2006. However, most subscribers covered by the Standard Plan, the Medicare Supplemental Plan or the health maintenance organizations offered through the Employee Insurance Program (EIP) should not sign up for Medicare Part D.

The prescription drug benefit you have through your health plan is as good as, or better than, Part D for most people. Because you have this coverage, your drug expenses will continue to be reimbursed through your health insurance. Before you become eligible for Medicare, you will receive a letter from EIP officially notifying you that you do not need to sign up for Part D. There is a copy of the letter on pages 189-191.

If you enroll in Medicare Part D, you will lose the prescription drug coverage provided by your health plan with EIP. However, the premium for your health plan will not be reduced.

Anyone covered by Medicare may sign up for Part D. However, there are costs, which vary according to which Part D plan you choose. In 2005 the federal government estimated a typical benefit would cost:

- A monthly premium of $32 (in addition to any premiums for Part A and Part B)
- A $250 annual deductible
- After the $250 annual deductible, coinsurance varying from 25 percent to 100 percent to 5 percent depending on how much you have paid for prescription drugs during the year.

You may have heard that if you do not sign up for Part D when you are first eligible—then later do so—you will have to pay higher premiums for Part D. For EIP subscribers, this is not true. According to Medicare rules, Medicare recipients who have "creditable coverage" (drug coverage that is as good as, or better than, Part D) and who later decide to sign up for Part D, will not be penalized by higher Part D premiums. Subscribers to the health plans offered through EIP have this kind of coverage. However, please save your Notice of Creditable Coverage letter from EIP in case you need to prove you had this coverage when you became eligible for Part D.

Please do not respond to information you may get from Medicare or advertisements from companies asking you to buy Part D prescription drug plans.

There is an exception:
If you are covered by Medicare, you may be eligible for higher benefits under Part D if your yearly income is less than $11,500 for individuals and less than $23,000 for married couples, and you have limited savings and investments. If you feel you may qualify, contact the Social Security Administration at 800-772-1213 or 800-325-0778 (TTY). You can only receive this extra assistance if you sign up for Part D.

Please remember:
Medicare Part D does not affect your need to enroll in Medicare Part B (medical insurance). As a retiree covered under EIP's insurance, you must enroll in Part A and Part B when you become eligible for Medicare due to a disability or due to age. If you are not enrolled in both parts of Medicare, your claims reimbursement for Part B services will be limited.

Medicare guarantees you coverage, regardless of your health, if you are eligible. There are no pre-existing conditions, limitations or exclusions. The Medicare + Choice program was created by the *Balanced Budget Act* of 1997. Individuals may now choose from a number of new health plan options in addition to Part A and Part B under the original Medicare program. Types of plans available, depending upon where you live, may include health maintenance organizations (HMOs), HMOs with Point of Service options, preferred provider organizations, provider-sponsored organizations, etc. You must have Medicare Part A and Part B to join a Medicare + Choice plan. These additional plan options are not addressed in this publication. Call Medicare or visit the Medicare Web site for additional information. To find out more about Medicare:

- Visit the Medicare Web site at www.medicare.gov.
- Call Medicare at 800-633-4227 or 877-486-2048 (TTY).

Medicare Before Age 65

If you or your spouse are eligible for Medicare due to disability, including end stage renal disease (ESRD), before age 65, you will be notified by the Social Security Administration. **You must notify EIP within 31 days of Medicare eligibility** to be advised of your options and to receive coordination of benefits with Medicare. When you notify EIP, please submit a copy of your Medicare card.

Medicare At 65

You should be notified of Medicare eligibility by the Social Security Administration three months before you reach age 65. If not, contact your local Social Security office. If you are already receiving Social Security benefits when you turn 65, Medicare Part A starts automatically and you should not turn down Part B. If you're not receiving Social Security, you should sign up for Medicare close to your 65th birthday. You should also notify EIP and submit a copy of your Medicare card.

If You Are an Active Employee

If you're actively working and/or covered under a state health plan for active employees, you do not need to sign up for Part B because your insurance as an active employee remains primary while you are actively working. However, if you are planning to retire within three months of age 65, you should contact Social Security concerning your enrollment options. Keep in mind that when you subsequently retire you should sign up for Part B within 31 days of retirement because Medicare becomes your primary coverage in retirement.

Sign up for Medicare

You must enroll in both Part A and Part B of Medicare to receive full benefits with any state-offered retiree group health plan. If you are not enrolled in both parts of Medicare, **your claims reimbursement for Part B services will be reduced**.

YOUR PLAN CHOICES AS A RETIREE ELIGIBLE FOR MEDICARE

When you and/or your eligible dependents are covered under retiree group health insurance and become eligible for Medicare, Medicare becomes the primary payer, and your health options change. EIP will send you a letter offering you and your eligible dependents a choice of the Standard Plan, the Medicare Supplemental Plan or a health maintenance organization offered in the county where you live. If you do not make a choice, you will be assigned to the Medicare Supplemental Plan. Coverage changes must be made within 31 days of Medicare eligibility.

If you are enrolled in the Medicare Supplemental Plan, your eligible dependent(s) without Medicare will have claims paid through the Standard Plan's provisions.

The Savings Plan and the TRICARE Supplement are not available to you if you are retired and eligible for Medicare.

The Medicare Supplemental Plan

When you become eligible for Medicare due to age or disability, you must notify EIP within 31 days. Because you have become eligible for Medicare, your health insurance options are the Medicare Supplemental Plan, the Standard Plan, CIGNA HealthCare HMO, BlueChoice HealthPlan or MUSC Options. The Savings Plan and the TRICARE Supplement are not available. If you do wish to elect the Medicare Supplemental Plan, you must do so within 31 days of eligibility or you will have to wait until the next open enrollment period.

TRICARE for Life

If you are a military retiree or an eligible spouse or dependent of a military retiree and you have Medicare Part B, you should also be eligible for TRICARE For Life. TRICARE For Life acts as a supplemental insurance to Medicare. If you have other insurance, such as the State Health Plan, TRICARE For Life will be the third payer after Medicare and the SHP. Please compare your benefits under TRICARE For Life and the SHP. For more information, call 866-773-0404 or visit www.tricareforyou.com.

If you have TRICARE For Life and wish to drop your SHP coverage, you should submit an NOE form to EIP or send EIP a written request for cancellation. Please note that the TRICARE Supplement is no longer available once you are eligible for Medicare. However, your covered dependents may continue their coverage under the TRICARE Supplement by paying premiums to ASI as long as they remain eligible for TRICARE, up to age 65.

HOW MEDICARE ASSIGNMENT WORKS

Under Medicare assignment, the Medicare subscriber agrees to have Medicare's share of the cost of services paid directly ("assigned") to a provider. Participating providers have agreed to submit all of their Medicare claims on an assigned basis. Non-participating providers may choose whether to accept assignment on each individual claim. If you receive services from a non-participating physician, ask if he will accept assignment.

Each year, doctors and suppliers have the opportunity to participate in the Medicare program. Those that participate will always accept the Medicare-approved amount as payment in full. Some doctors accept assignment; some do not. If a doctor does not accept assignment, you may end up paying more for his or her services.

If a doctor decides to participate, he cannot drop out in the middle of the year. Independent laboratories and doctors who perform diagnostic laboratory services and non-physician practitioners must accept assignment.

THE STATE HEALTH PLAN IN RETIREMENT

This section explains the key features of the State Health Plan (SHP) in retirement. If you and/or your covered dependents are not eligible for Medicare, the SHP offers you and your dependents a choice between the *Standard Plan* and the *Savings Plan*. Refer to the State Health Plan section of this guide for a more complete overview of the benefits offered under these two plans.

Once you and/or your covered dependents become eligible for Medicare, the SHP offers the *Standard Plan* and the *Medicare Supplemental Plan*, which are outlined in the next two sections. The Savings Plan is no longer available to you, and you may no longer contribute to a Health Savings Account (HSA). However, if you still have funds in your HSA, you may continue to use the money tax-free for qualified medical expenses and to pay Medicare premiums.

Are you wondering how the SHP Standard Plan measures up when compared to other health insurance options available to you when you become eligible for Medicare?

Refer to page 162 for a detailed comparison table.

THE SHP STANDARD PLAN

The SHP Standard Plan offers worldwide coverage. It requires Medi-Call approval for inpatient hospital admissions; all maternity benefits (you must call in the first trimester); outpatient surgical services in a hospital or clinic; the purchase or rental of durable medical equipment; and skilled nursing care, hospice care and home healthcare. You must also call APS Healthcare, Inc., administrator for the SHP's mental health and substance abuse benefits, for pre-authorization before you receive mental health or substance abuse care.

The plan has both deductibles and coinsurance. Once you become eligible for Medicare, the Standard Plan uses a carve-out method of claims payment, described on page 144.

HOW THE SHP STANDARD PLAN AND MEDICARE WORK TOGETHER

SHP Hospital Network

When you are eligible for Medicare, Medicare is the primary payer, and you may go to any hospital you choose. Medicare limits the number of days it will cover for hospital stays. If you are enrolled in the Standard Plan and your hospital stay exceeds the number of days allowed under Medicare, it may be important to you that you are admitted to a hospital within the SHP network or BlueCard Program so that you will not be charged more than what the Standard Plan allows. *Note: Mental health and substance abuse services are covered only at APS Healthcare, Inc., network facilities.*

You must also call Medi-Call for approval of any additional inpatient hospital days and for services related to home healthcare, hospice, durable medical equipment and Veterans Administration hospital services.

Using Medi-Call as a Retiree

Medicare has its own utilization review program. However, you will still need to call Medi-Call when Medicare benefits are exhausted for inpatient hospital services (including hospital admissions outside of the state or country), and for extended care services, such as skilled nursing facilities, private duty nursing, home healthcare, durable medical equipment and Veterans Administration hospital services. *Note: Any covered family members, who are not eligible for Medicare and have their claims processed under the SHP, must call Medi-Call.* Please remember that while your physician or hospital may call Medi-Call for you, it is your responsibility to see that it is done.

Private Duty Nursing if You Have Medicare

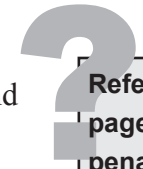
Medicare does not cover private duty nursing; however, the Standard Plan does. The regular coinsurance rate applies for approved charges. Remember to call Medi-Call for private duty nursing services.

When Traveling Outside South Carolina

You are not generally covered outside the United States under Medicare. However, if you are enrolled in the Standard Plan, you have worldwide access to doctors and hospitals through the BlueCard program. If you are admitted to a hospital outside the state or the country as a result of an emergency, notify Medi-Call and follow the BlueCard guidelines. For more information, see page 27.

Mental Health and Substance Abuse: Using APS as a Retiree

If you are eligible for Medicare and covered under the Standard Plan, you must call APS Healthcare, Inc., administrator of the SHP mental health and substance abuse benefit, at 800-221-8699 for approval of inpatient hospital stays. Pre-authorization and continued-stay authorizations by APS are required for inpatient care, including care in a Veterans Administration hospital. If your Medicare benefits are exhausted, you must call APS to receive authorization for continued benefits under the Standard Plan. To receive benefits, you must use an APS network provider. Note: Any covered family members, who are not eligible for Medicare and have their claims processed under the SHP, must also call to register with APS and use an APS network provider.



Refer to the following pages for details about penalties for not calling Medi-Call or APS for pre-authorization.

- **Medi-Call: page 30**
- **APS: page 42**

Prescription Drug Program

The Standard Plan covers prescription drugs when purchased from a participating pharmacy. Please refer to pages 39-42 for more information on the SHP Prescription Drug Program.

Ambulatory Surgical Center Network

These facilities provide some of the same services offered in the outpatient department of a hospital. If you are enrolled in Medicare, there is no need to call Medi-Call for pre-authorization, nor do you need to select a center that participates in the network.

Transplant Contracting Arrangements

As part of this network, you have access to the leading transplant facilities in-state and throughout the nation. If you are enrolled in Medicare, there is no need to call Medi-Call for pre-authorization, nor do you need to select a facility that participates in the network.

Mammography Testing Benefit

The SHP allows covered women, ages 35-74, to have routine mammograms. You may have one baseline mammogram if you are age 35-39, one routine mammogram every other year if you are age 40-49 and one routine mammogram every year if you are age 50-74. There is no charge if you use a facility that participates in the program's network.

Medicare allows yearly routine mammograms for women age 40 and older and pays 80 percent of Medicare-approved charges. Check with the testing facility to see if it accepts Medicare assignment.

Pap Test Benefit

The SHP will pay for yearly Pap tests for covered women ages 18-65 whether the Pap test is routine or diagnostic. The deductible and coinsurance do not apply to this benefit. This benefit does not include the doctor's office visit or other lab tests. Medicare covers a Pap test, pelvic exam and clinical breast exam *every other year*. (If you are at high risk, you may have one yearly. Check with Medicare for more information.) Medicare pays 100 percent for the test, 80 percent for the exam and collection. Please note that the SHP Standard Plan will pay for Pap tests *every year,* so you may take advantage of this benefit in the years that Medicare does *not* pay.

Maternity Management and Well Child Care Benefits

The SHP offers two programs geared toward early detection and prevention of illness among children. The Maternity Management benefit helps mothers-to-be covered by the SHP receive necessary prenatal care. (This benefit applies to covered retirees and their spouses. It does not apply to dependent children.) The Well Child Care benefit offers coverage for routine check-ups and immunizations of children through age 12. Medicare does not provide similar coverage

"CARVE-OUT" METHOD OF CLAIMS PAYMENT

The Standard Plan coordinates with Medicare on the basis of the SHP-approved charge. The carve-out method of claims payment works just like coordination of benefits with any other plan. When an individual is covered by two insurance plans, one pays first and the other pays second. If your provider accepts Medicare assignment, the Standard Plan will pay the lesser of:

1. The Medicare-allowed amount, minus the Medicare-reported payment or
2. The amount the plan would pay in the absence of Medicare, minus the Medicare-reported payment.

If your provider does not accept Medicare assignment, the Standard Plan pays the difference between the SHP's allowable amount and the amount Medicare reported paying. If the Medicare payment exceeds the SHP's allowable amount, the Standard Plan will not pay a benefit. The Standard Plan will never pay for charges that are more than the SHP's allowable amount. With the Standard Plan, your total benefits (Medicare plus the SHP) will be equivalent to those offered to active employees and to retirees not eligible for Medicare.

***Example**:*
The hospital bill for a January admission is $7,500. If you are enrolled in Medicare only, your claim will be processed like this:

$7,500	Hospital bill
- $952	Medicare Part A deductible for 2006 (you pay)
$6,548	Medicare payment
$ 952	You pay (unless you have another health plan)

If you are enrolled in the Standard plan and Medicare, your claim will be processed like this:

$7,500	Hospital bill
- $350	Standard Plan deductible for 2006 (you pay)
$7,150	Standard Plan liability
x 80%	Standard Plan coinsurance (you pay 20%, $1,430)
$5,720	Amount the plan would pay in the absence of Medicare
- 6,548	Amount paid by Medicare
$ -0-	Standard Plan pays nothing, you pay the lesser of 20 percent or the balance of bill, which would be $952.*

*You pay the 20 percent coinsurance or the balance of the bill, whichever is less. In this example, your 20 percent coinsurance of $1,430, plus the $350 deductible, is $1,780. However, the balance of the bill is only $952, so you pay $952. Once you reach your $2,000 coinsurance maximum, all claims will be allowed at 100 percent of the allowable charge based on the carve-out method of claims payment. All Medicare deductibles and Medicare Part B (20 percent coinsurance) should be paid in full for the rest of the calendar year after you reach your $2,000 coinsurance maximum.

FILING CLAIMS AS A RETIREE

Medicare is your primary carrier. In most cases, your provider will file your Medicare claims for you.

Claims Filed in South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved charges incurred in South Carolina should be transferred automatically from Medicare to the SHP for you. Your mental health and substance abuse provider should file claims for you with APS, including Medicare payment information. If you or your doctor have not received payment or notification from the SHP within 30 days after the Medicare payment is received, one of you must send BlueCross BlueShield of South Carolina (BCBSSC), claims administrator for the SHP, a claim form and a copy of your Explanation of Medicare Benefits with your SHP subscriber identification number written on it.

Claims Filed Outside South Carolina

If you receive services outside South Carolina, your provider will file the claim with the Medicare carrier in that state. If you or your doctor have not received payment or notification from the SHP within 30 days after the Medicare payment is received, one of you must send BlueCross BlueShield of South Carolina (BCBSSC), claims administrator for the SHP, a claim form and a copy of your Explanation of Medicare Benefits with your SHP subscriber identification number written on it.

If Medicare Denies Your Claim

If Medicare denies your claim, including denied Pap test claims, you are responsible for filing the denied claim to BCBSSC. You may use the same SHP claim form as active employees do. These forms are available from EIP or BCBSSC. You will need to attach your Explanation of Medicare Benefits and an itemized bill to your claim form.

Railroad Retirement Claims

If you receive benefits from the Railroad Retirement Board (RRB), you must first file claims with the RRB. When you get an explanation of benefits, mail it, along with an itemized bill and claim form, to BCBSSC for processing.

THE MEDICARE SUPPLEMENTAL PLAN

You may enroll in this plan when you retire if you are eligible for Medicare, or during a designated enrollment period for the Medicare Supplemental Plan. Designated Medicare Supplemental Plan enrollment periods are held during open enrollment in October of odd-numbered years (2007). During this time, you can change from the Standard Plan or an HMO to the Medicare Supplemental Plan or vice versa. Plan changes are effective on January 1 following the enrollment period. If you are enrolled in a health plan, you may change to the Medicare Supplemental Plan within 31 days of eligibility for Medicare.

This section explains the SHP Medicare Supplemental Plan, which is available to retirees and covered dependents who are enrolled in both Parts A and B of Medicare. This plan coordinates benefits with the original Medicare Plan only. No benefits are provided for coordination with Medicare Advantage Plans. For more information, visit www.medicare.gov.

General Information

The Medicare Supplemental Plan is similar to a Medigap policy—it fills the "gap" or pays the portion of Medicare-approved charges that Medicare does not, such as Medicare's deductibles and coinsurance. The Medicare Supplemental Plan payment is based on Medicare-approved charges. Charges not approved by Medicare will not be considered for benefits under the Supplemental Plan, except as specified on pages 146-149 with Medi-Call approval. If your medical provider does not accept Medicare assignment, and charges you more than what Medicare allows, you pay the difference.

MEDICARE DEDUCTIBLES AND COINSURANCE

Deductibles

Medicare Part A has an inpatient hospital deductible for each *benefit period*. That deductible is $952 for 2006. A Medicare benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received any hospital or skilled care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. *The Medicare Supplemental Plan pays the Part A deductible.*

Medicare Part B has a deductible of $124 a year. Part B also includes a monthly premium of $88.50 for 2006 and covers physician services, supplies and outpatient care. As a retiree, you should enroll in Part B as soon as you are eligible for Medicare, because Medicare becomes your primary coverage. *The Medicare Supplemental Plan pays the Part B deductible.*

Coinsurance

Medicare Part B pays 80 percent of Medicare-approved charges (50 percent for outpatient mental healthcare). *The Medicare Supplemental Plan pays the remaining 20 percent (50 percent for outpatient mental healthcare).*

MEDICARE SUPPLEMENTAL PLAN DEDUCTIBLES AND COINSURANCE

The Medicare Supplemental Plan benefit period is from January 1-December 31 and includes a $200 deductible each calendar year that applies to private duty nursing services only. If you become eligible for Medicare and change to the Medicare Supplemental Plan during the year, you must meet a new $200 deductible for private duty nursing services. You do not have to meet another $200 deductible for private duty nursing services if you remain enrolled in the Standard Plan.

WHAT THE MEDICARE SUPPLEMENTAL PLAN COVERS

Hospital Admissions

The Medicare Supplemental Plan pays these expenses for Medicare-covered services after Medicare Part A benefits have been paid during a benefit period:

- The Medicare Part A hospital deductible
- The coinsurance, after Medicare pays, for days 61-150 of hospitalization, up to the Medicare-approved charge (Medicare pays 100 percent for the first 60 days)
- 100 percent of the Medicare-approved charges for hospitalization beyond 150 days, if medically necessary (Medicare does not pay beyond 150 days.)*
- The coinsurance for durable medical equipment up to the Medicare-approved charge.

**Must call Medi-Call or APS for approval.*

Additional Days in a Hospital

If you are enrolled in Medicare, Medicare is the primary payer, and you may go to any hospital you choose. However, Medicare pays nothing for hospital stays beyond 150 days.

If You Exceed the Number of Inpatient Hospital Days Allowed Under Medicare:
If you are enrolled in the Medicare Supplemental Plan and you exhaust all Medicare-allowed inpatient hospital days, you must call Medi-Call for approval of any additional inpatient hospital days. If your extended stay is approved, the Medicare Supplemental Plan will pay for the Medicare-approved expenses. So, if you are enrolled in the Medicare Supplemental Plan and you expect your hospital stay may exceed the number of days allowed under Medicare, you should choose a hospital within the SHP network or BlueCard Program so that any additional days beyond what Medicare allows will be covered by the Medicare Supplemental Plan.

You must also call Medi-Call for services related to home healthcare, hospice, durable medical equipment and Veterans Administration hospital services.

Skilled Nursing Facilities

The Medicare Supplemental Plan will pay these benefits after Medicare has paid benefits during a benefit period:
- The coinsurance, after Medicare pays, up to the Medicare-approved charge for days 21-100 (Medicare pays 100 percent for the first 20 days)
- 100 percent of the Medicare-approved charges beyond 100 days in a skilled nursing facility if medically necessary (Medicare does not pay beyond 100 days.)* The maximum benefit per year is $6,000, which includes the coinsurance between the 21st and 100th day.

**Must call Medi-Call for approval.*

Physician Charges

The Medicare Supplemental Plan will pay these benefits related to physician services approved by Medicare:
- The Medicare Part B deductible
- The coinsurance of the Medicare-approved charge for physician's services for surgery, necessary home and office visits, hospital visits and other covered physician's services
- The coinsurance for Medicare-approved charges for physician's services rendered in the outpatient department of a hospital for treatment of accidental injury, medical emergencies, minor surgery and diagnostic services.

Home Healthcare

The Medicare Supplemental Plan will pay these benefits for medically necessary home healthcare services:
- The Medicare Part B deductible
- The coinsurance for any covered services or costs Medicare does not cover (Medicare pays 100 percent for Medicare-approved charges), up to 100 visits or $5,000 per benefit year, whichever occurs first. The plan does not cover services provided by a person who ordinarily resides in the home, is a member of the family or a member of the family of the spouse of the covered person.
- 20 percent of Medicare-approved charges for Durable Medical Equipment

Private Duty Nursing Services

Private services provided by a registered nurse (RN) or a licensed practical nurse (LPN) that have been certified in writing by a physician as medically necessary. There is a $200 annual deductible that applies, regardless of the time of year you enroll in the plan. Medicare does NOT cover this service. Once the deductible is met, the Medicare Supplemental Plan will pay 80 percent of covered charges for private duty nursing in a hospital or in the home. Coverage is limited to no more than three nurses per day, and the maximum annual benefit per year is $5,000. The lifetime maximum benefit under the Medicare Supplemental Plan is $25,000.

Prescription Drugs

The Medicare Supplemental Plan covers prescription drugs when purchased from a participating pharmacy under the SHP's Prescription Drug Program, administered by Medco. For more information, refer to pages 39-42.

Diabetic Supplies

Medicare covers some diabetic supplies for people enrolled in Medicare (insulin users and non-insulin users). These include limited quantities of:
- Blood glucose test strips. All Medicare-enrolled pharmacies and suppliers must submit claims for glucose monitor test strips. You cannot send in the claim for glucose test strips yourself.
- Blood glucose meter
- Lancet devices and lancets and
- Glucose control solutions for checking the accuracy of test strip monitors. For more information on how Medicare covers diabetic supplies, go to Medicare's Web site at www.medicare.gov.

When Traveling Outside the United States

Although the SHP hospital network includes hospitals across the country and around the world through the BlueCard Program, administered by BlueCross BlueShield of South Carolina, Medicare does not cover services outside the United States. Since the Medicare Supplemental Plan does not allow benefits for services not covered by Medicare (other than private duty nursing), the BlueCard Program does not cover Medicare Supplemental Plan subscribers.

Using Medi-Call

Medicare has its own utilization review program. You will need to call Medi-Call only when Medicare benefits are exhausted for inpatient hospital services and for extended care services, such as skilled nursing facilities, private duty nursing, home healthcare, durable medical equipment and Veterans Administration hospital services. *Note: Any covered family members, who are not eligible for Medicare and have their claims processed under the SHP, must call Medi-Call.*

Refer to the following pages for details about penalties for not calling Medi-Call or APS for pre-authorization.
- **Medi-Call: page 30**
- **APS: page 42**

Mental Health and Substance Abuse

If your claims are processed under the Medicare Supplemental Plan, you are encouraged, but not required to call APS, administrator of the SHP mental health and substance abuse benefit, because Medicare guidelines will apply. However, if you exhaust Medicare's allowed inpatient hospital days, you must call APS for approval of any additional inpatient hospital days, including those in Veterans Administration hospitals. Pre-authorization and continued stay authorizations from APS are required for inpatient care, including Veterans Administration hospital services. However, you are not required to use an APS network provider. *Note: Any covered family members who are not eligible for Medicare and have their claims processed under the SHP must call to register with APS and must use an APS network provider.*

Ambulatory Surgical Center Network

The Ambulatory Surgical Center Network includes facilities throughout the state that provide some of the same services as provided in the outpatient departments of hospitals. These centers accept the SHP's allowed charges and will not charge you more. If you are enrolled in Medicare, there is no need to call Medi-Call for pre-authorization, nor do you need to select a center that participates in the SHP network.

Transplant Contracting Arrangements

As part of this network under the SHP, you have access to the leading transplant facilities in the nation, including in-state providers of transplant services. If you are enrolled in Medicare, there is no need to call Medi-Call for pre-authorization, nor do you need to select a facility that participates in the SHP network.

Mammography Testing Benefit

If you are enrolled in Medicare, Medicare allows yearly routine mammograms for women ages 40 and older and pays 80 percent of the Medicare-approved amount. The Medicare Supplemental Plan pays the 20 percent coinsurance. The providers may ask for a physician's referral.

Pap Test Benefit

If you are enrolled in Medicare, Medicare covers a Pap test, pelvic exam and clinical breast exam every other year. (These tests are covered yearly if you are at high risk. Check with Medicare for more information.) Medicare pays 100 percent for the Pap lab test; 80 percent of the Medicare-approved amount for the Pap test collection and the pelvic and breast exam. The Medicare Supplemental Plan pays the 20 percent coinsurance.

Please note that the Medicare Supplemental Plan will pay for Pap tests for covered women, ages 18-65, *every year,* so you may take advantage of this benefit in the years that Medicare does *not* pay. The Pap test benefit applies whether or not the Pap test is routine or diagnostic. The deductible and coinsurance do not apply to this benefit. This benefit does not include the doctor's office visit or other lab tests.

Maternity Management and Well Child Care Benefits

The Medicare Supplemental Plan offers benefits geared toward early detection and prevention of illness among children. The Maternity Management benefit helps mothers-to-be covered by the SHP receive necessary prenatal care. (This benefit applies to covered retirees and spouses; it does not apply to dependent children.) The Well Child Care benefit offers coverage for routine check-ups and immunizations of children through age 12. If you are enrolled in Medicare, you may want to know that Medicare does not provide similar coverage. Refer to page 31 for more information on these benefits.

Medicare Assignment

If the provider accepts Medicare assignment, the provider accepts Medicare's payment plus the Medicare Supplemental Plan's payment as payment in full. If the provider does not accept Medicare assignment, the provider may charge more than what Medicare and the Medicare Supplemental Plan pay combined. You would pay the difference.

Example:
Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500	Hospital bill
- 952	Medicare Part A deductible for 2006
$6,548	Medicare payment
$ 952	You pay (unless you have another health plan)

The Medicare Supplemental Plan will pay all Medicare deductibles and coinsurance:

$ 952	Medicare Supplemental Plan pays Medicare Part A deductible
+6,548	Amount paid by Medicare
$7,500	Bill paid in full

Filing Claims as a Retiree

If you are enrolled in Medicare, Medicare is your primary carrier. In most cases, your provider will file your Medicare claims for you.

Claims Filed Inside South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved charges incurred in South Carolina should be transferred automatically from Medicare to the SHP for you. Your mental health and substance abuse provider should file claims to APS with Medicare payment information. If you or your doctor have not received payment or notification from the Plan within 30 days after the Medicare payment is received, one of you must send BlueCross BlueShield of South Carolina (BCBSSC), claims administrator for the SHP, a claim form and a copy of your Explanation of Medicare Benefits with your subscriber identification number written on it.

Claims for covered family members who are not eligible for Medicare, but who are insured through the Medicare Supplemental Plan, are paid according to the Standard Plan provisions. The carve-out method does not apply to family members who are not eligible for Medicare.

Claims Filed Outside South Carolina

If you receive services outside South Carolina, your provider will file its claim to the Medicare carrier in that state. When you receive your Explanation of Medicare Benefits, you must send it to BCBSSC for medical or surgical services or to APS for mental health and substance abuse services. You also must include a claim form and an itemized bill.

If Medicare Denies Your Claim

If Medicare denies any of your claims, including Pap test claims, you are responsible for filing the denied claim to BCBSSC. You may use the same SHP claim form that active employees do. These forms are available from EIP or BCBSSC. You will need to attach your Explanation of Medicare Benefits and an itemized bill to your claim form.

Railroad Retirement Claims

If you receive benefits from the Railroad Retirement Board (RRB), you must first file claims with the RRB. When you get an explanation of benefits from the RRB, mail it, along with an itemized bill and claim form, to BCBSSC for processing.

HMO PLANS IN RETIREMENT

This section explains some key distinctions of the health maintenance organizations (HMOs) and how they work together with Medicare. For a more complete overview of the plans, refer to the HMO section of this guide or contact the HMO.

An HMO typically does not cover care outside its network, except in an emergency. If it is important to you to use particular providers, including physicians and hospitals, it is best to check to see if those providers participate in the HMO you wish to join.

Refer to page 14 for more information about COBRA continuation coverage.

Refer to page 10 for more information about special eligibility situations.

Remember, you must live in an HMO's service area to enroll. Not all HMOs are available in all South Carolina counties. A list of counties where each HMO is offered is on page 50.

IF YOU ARE ELIGIBLE FOR MEDICARE

BlueChoice HealthPlan HMO, CIGNA HMO and MUSC Options are available if you live in a county where they are offered. This section will focus on these plans.

Provider Networks

A traditional HMO provides a list of participating network doctors from which you choose a primary care physician. This doctor coordinates your care, which means you must contact him to be referred to specialists who also participate in the HMO's network. Network providers file the claims for you. If you belong to an HMO, the plan covers only medical services received from network providers. If you receive care outside the network, benefits are not paid. Typically, the only services you receive from out-of-network providers that most HMOs cover are those for medical emergencies.

When Traveling Outside the Network or the U.S.

When traveling outside the CIGNA, MUSC Options or BlueChoice HealthPlan networks, you will be covered for emergency medical care. If your insurance identification cards are not recognized by the treating hospital, you may be required to pay for the services, then later file a claim for reimbursement.

Prescription Drug Programs

The HMOs offered for 2006 include a prescription drug program with participating pharmacies.

HOW BLUECHOICE HEALTHPLAN HMO AND MEDICARE WORK TOGETHER

BlueChoice HealthPlan HMO pays only Medicare-approved charges. It supplements Medicare by paying the Medicare Part A (hospital) and Part B (medical) deductibles in full. The plan also pays the 20 percent coinsurance left after Medicare pays 80 percent for Part B-approved services.

This plan pays the coinsurance for hospitalization after the first 60 days in a general hospital or after the first 20 days in a skilled nursing facility. (Medicare pays 100 percent of the Medicare-approved amount for the first 60 days in a general hospital and for the first 20 days of skilled nursing care.) BlueChoice HealthPlan also pays the Medicare coinsurance for days 21-100 for skilled nursing care.

If the provider accepts Medicare assignment, the provider will consider Medicare's payment plus BlueChoice HealthPlan's as payment in full. If the provider does not accept Medicare assignment, the provider may charge more than what Medicare and BlueChoice pay combined. The subscriber would pay the difference.

Example:
Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500	Hospital bill
- 952	Medicare Part A deductible for 2006
$6,548	Medicare payment
$ 952	You pay (unless you have other coverage)

BlueChoice HealthPlan pays all Medicare deductibles and coinsurance:

$ 952	BlueChoice HealthPlan pays Medicare Part A deductible
+6,548	Amount paid by Medicare
$7,500	Bill paid in full

If you are enrolled in Medicare, Medicare is your primary coverage. In most cases, your provider will file your Medicare claims for you. The Medicare claim should be filed first.

Additional information about BlueChoice HealthPlan is provided in the HMO chapter of this guide.

HOW CIGNA HMO AND MEDICARE WORK TOGETHER

CIGNA's HMO pays the lesser of the subscriber's unreimbursed allowable expense under Medicare or CIGNA's normal liability. If the balance due on the claim is less than the normal liability, then CIGNA will pay the balance due.

CIGNA's benefit credit saving provisions apply. A *benefit credit* is the portion of the claim that CIGNA does not have to pay as a result of a coordination of benefits with Medicare. It may be applied to future claims during the calendar year. *Benefit credit saving* is the difference between what CIGNA would normally be responsible for paying and CIGNA's actual payment. It applies only to the family member who incurs the charge, and it expires at the end of the calendar year in which it is gained. Contact CIGNA HealthCare for additional information.

Example:
Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500	Hospital bill
- 952	Medicare Part A deductible
$6,548	Medicare payment
$ 952	Balance due

If you are enrolled in CIGNA's HMO plan your claim will be paid like this:

$7,500	Hospital bill
- 500	CIGNA's inpatient per occurrence copayment
$7,000	
x 80%	CIGNA's coinsurance
$5,600	CIGNA's liability in absence of Medicare
- 952	Amount paid by CIGNA in coordination with Medicare
$4,648	Benefit credit savings with CIGNA

Filing Claims as a Retiree

If you are enrolled in Medicare, Medicare is your primary coverage. In most cases, your provider will file your Medicare claims for you. The Medicare claim should be filed first.

For more information, contact CIGNA.

HOW MUSC OPTIONS AND MEDICARE WORK TOGETHER

Beginning January 1, 2006, MUSC Options became available to Medicare recipients living in Berkeley, Charleston, Colleton and Dorchester counties. The health maintenance organization with a point of service option pays only Medicare-approved charges. It supplements Medicare by paying the Medicare Part A (hospital) and Part B (medical) deductibles in full. The plan also pays the 20 percent coinsurance left after Medicare pays 80 percent for Part B-approved services.

MUSC Options pays the coinsurance for hospitalization after the first 60 days in a general hospital or after the first 20 days in a skilled nursing facility. (Medicare pays 100 percent of the Medicare-approved amount for the first 60 days in a general hospital and for the first 20 days of skilled nursing care.) It also pays the Medicare coinsurance for days 21-100 for skilled nursing care.

If the provider accepts Medicare assignment, the provider will consider Medicare's payment plus MUSC Options' as payment in full. If the provider does not accept Medicare assignment, the provider may charge more than what Medicare and MUSC Options pay combined. The subscriber would pay the difference.

Example:
Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500	Hospital bill
- 952	Medicare Part A deductible for 2006
$6,548	Medicare payment
$ 952	You pay (unless you have other coverage)

MUSC Options pays all Medicare deductibles and coinsurance:

$ 952	MUSC Options pays Medicare Part A deductible
+6,548	Amount paid by Medicare
$7,500	Bill paid in full

If you are enrolled in Medicare, Medicare is your primary coverage. In most cases, your provider will file your Medicare claims for you. The Medicare claim should be filed first.

Additional information about the MUSC Options plan is provided in the HMO chapter of this guide.

DENTAL BENEFITS

If you retire from a participating employer, you can continue your State Dental Plan and Dental Plus coverage, if you meet the eligibility requirements (see page 135). Coverage is not automatic. You must file a Notice of Election (NOE) with EIP within 31 days of your retirement date, the date your TERI plan ends or date of disability approval to maintain continuous coverage.

If you are not eligible for retiree insurance, you must request COBRA continuation coverage within 60 days of loss of coverage or notification of the right to continue coverage, whichever is later.

If you do not enroll within 31 days of your date of retirement, you may enroll during the next open enrollment period (October 2007). Coverage will be effective the following January 1. You also may enroll within 31 days of a special eligibility situation. For information on the State Dental Plan and Dental Plus, see pages 63-70.

LIFE INSURANCE

$3,000 Basic Life Insurance

This benefit is given to you as an active employee and *ends* with retirement or when you leave your job for another reason. You may convert the $3,000 Basic Life to an individual policy through The Hartford within 31 days of the date coverage ends. Contact your benefits office or EIP for additional information.

Refer to pages 71-91 for more information about Life Insurance. Premiums are listed on pages 89-91.

South Carolina Retirement Systems (SCRS) Retiree Group Life Insurance

As a retiree, if you die and your last employer before retirement participates in the Retiree Group Life Insurance program, a benefit, based on your retirement-credited service in the SCRS, will be paid by the SCRS to your beneficiaries as follows:

SCRS	PORS
10-19 years service credit=$2,000	10-19 years service credit=$2,000
20-27 years service credit=$4,000	20-24 years service credit=$4,000
28 or more years service credit=$6,000	25 or more years service credit=$6,000

OPTIONAL LIFE INSURANCE

This is how you can carry your Optional Life Insurance into retirement through The Hartford:

- If you retired on or after January 1, 2001, you may continue your coverage in $10,000 increments up to the final face value of coverage until age 75. At age 70, coverage is reduced for active employees and retirees.
- You may convert your Optional Life coverage to an individual policy.
- You may split your coverage between universal life insurance and term life insurance.

Retiree coverage does not include the Travel Assistance Program, the Living Benefit or the Accidental Death, Seat Belt Rider and Dismemberment provisions. To continue your coverage, you must complete the required enrollment forms within 31 days of your date of retirement. If you are leaving employment due to a disability and are continuing Optional Life coverage under the 12-month waiver provision, you must file for continuation within 31 days of the end of the 12-month waiver. If you have questions about continuing your coverage as a retiree, contact your benefits office or EIP.

If you participate in the Teacher and Employee Retention Incentive (TERI) program, you continue your benefits as an active employee, provided you are eligible. When the TERI period ends you must file for retiree benefits within 31 days as indicated above.

If you continue coverage as a retiree and return to work as a full-time, active employee with a participating employer, you must choose whether to enroll in Optional Life insurance coverage as an active employee or to continue your retiree coverage. Participation in both programs is prohibited. Your active group coverage will become effective only if you end the retiree continuation coverage.

Premiums are on pages 89-91.

Optional Life if You Become Disabled

If you become totally disabled while covered as an active employee, your life insurance will be continued for up to 12 months from the last day you are physically at work, provided:

- Your total disability began while you were covered by this Optional Life Insurance plan
- Your total disability began before you reached age 69 and
- The group Optional Life Insurance policy does not end.

Your premiums will be waived for up to 12 months from the last day you were physically at work as long as you are totally disabled. The 12-month waiver period begins the first of the month following your last day physically at work. For your premiums to be waived, you must provide proof of disability to your benefits administrator within one year after the last day you were physically at work. If you return to work during the 12-month waiver period and work one full week, the premium waiver period should end. If you must leave employment again due to total disability, the 12-month waiver will start over from the last day you were physically at work.

When the waiver ends, you must file for continuation through The Hartford within 31 days of the date the waiver ends. Contact your benefits office for additional information.

The Pretax Group Insurance Premium Feature and Accidental Death and Dismemberment benefits do not apply to retirees.

DEPENDENT LIFE INSURANCE

Any Dependent Life Insurance coverage you have will end when you leave active employment. Your covered dependent may convert the insurance coverage to an individual policy. The dependent must apply to The Hartford, in writing, within 31 days of the date of coverage ends and pay the required premiums.

LONG TERM DISABILITY

Disability insurance protects an employee and his family from loss of income due to an injury or an extended illness that prevents the employee from working. When you leave active employment, your Basic and Supplemental Long Term Disability end. However, in retirement your income is guaranteed for your lifetime, and beyond, if you select a retirement annuity with a survivor option.

Basic Long Term Disability

This benefit may not be continued or converted to an individual policy.

Supplemental Long Term Disability

Generally, you may not continue Supplemental Long Term Disability coverage in retirement. However, if you are retiring or leaving employment, but plan to work for an employer that does not have a supplemental long term disability program, contact the EIP for more information about continuing coverage through Standard Insurance Company.

LONG TERM CARE

Long Term Care (LTC) refers to a wide range of personal healthcare services for people of all ages who suffer from chronic conditions. These individuals often need custodial care rather than skilled care. Custodial care is assistance with the activities of daily living: bathing, eating, continence, toileting, dressing and transferring. This care can be provided in a nursing home, an adult daycare center or at home and is generally not covered by health insurance.

Long Term Care Services Already Covered

Medicare covers some home healthcare and skilled nursing facility services. However, there are limits on the dollar amounts paid and the number of visits allowed. Neither the SHP nor Medicare covers custodial care services. To qualify for Medicaid, you must exhaust most of your assets and income.

Continuing Coverage Into Retirement

If you are enrolled in LTC when you retire, your coverage will be continued. Each family member covered when you retire will also have continued coverage. You will receive a letter, which you will need to sign and return to EIP, regarding continuation of your LTC coverage.

Enrolling in Coverage at Retirement

You and/or your spouse/surviving spouse may enroll in LTC at any time by providing medical evidence of good health. Ask Aetna or EIP for information and an application. If you are approved for coverage, Aetna will send confirmation to you and to EIP.

Premiums

You pay the entire cost of LTC coverage for yourself and your spouse, if he or she is enrolled. Premiums will be based on your age at the time of your application. (Some exceptions may apply.) Premiums may be found on pages 176-178. EIP will deduct the premiums from your monthly SCRS check. However, if the amount is not enough to cover your health, dental and LTC premiums, Aetna will bill you directly for LTC premiums. Local subdivision retirees will be billed by the local subdivision. You may also request in writing to have your premiums drafted from your bank account.

MONEYPLU$ IS NOT AVAILABLE IN RETIREMENT.

VISION CARE PROGRAM

This discount program is available to all retirees, as well as to all full-time and part-time employees, dependents, survivors and COBRA subscribers. Please refer to pages 16-17 for more information.

RETURNING TO WORK

Since the earnings limitation for service retirees of the S.C. Retirement Systems has been eliminated, more individuals are electing to receive their retirement benefits while continuing to work. In addition, people who are already retired are returning to work.

Deciding on Coverage

If you are covered under the retiree group insurance program and return to active employment in a permanent, full-time position, you must decide whether to be covered under the active group employee benefits or to continue your retiree group benefits. You cannot be covered under both. If you prefer to continue your retiree group insurance benefits, you must complete and sign an Active Group Benefits Refusal form. Remember, if you refuse to enroll as an active employee, you are also refusing benefits that are available to active employees only:

- $3,000 Basic Life benefit
- Basic and Supplemental Long Term Disability coverage
- Dependent Life Insurance
- Optional Life Insurance
- MoneyPlu$ benefits

Note: If you carried your Optional Life coverage into retirement and/or converted your Dependent Life coverage, and are billed by The Hartford, you must decide if you want coverage as a retiree or as an active employee. You cannot have both.

If You Are Enrolled in Medicare

If you are enrolled in Medicare and return to active employee benefits, Medicare will become the secondary payer to the active group coverage. Therefore, you must notify Social Security that you are covered under the active group, and you may elect to drop Medicare Part B while you are covered as an active employee. When you leave active employment and your active group coverage ends, you may return to retiree group coverage. You must file an enrollment form to return to the state retiree group. In addition, you must notify Social Security that you are no longer covered under an active group so that you can re-enroll in Medicare Part B.

TERI PROGRAM

How TERI Affects Your Insurance Coverage

If you are participating in the TERI program, you continue your insurance coverage under the **active** group insurance program as long as you are eligible. At the end of your TERI period, you must file for continuation of coverage as a retiree within 31 days. For more information on the TERI program, contact SCRS.

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Comparison of Health Plan Benefits for Retirees

Type	**High Deductible Health Plan**		**Preferred Provider Organization**		
	Once the deductible has been met, other benefits are paid at the same level as the SHP Standard Plan.		To receive the higher level of benefits, subscribers should choose a network provider.		
Plan	**SHP Savings Plan**		**SHP Standard Plan**		
Availability	Coverage Worldwide		Coverage Worldwide		
Annual Deductible ***Single*** ***Family***	**$3,000** **$6,000**[1]		**$350** **$700**		
Hospitalization/ Emergency Care	No per-occurrence deductibles or copays		Outpatient hospital: **$75** per-occurrence deductible Emergency care: **$125** per-occurrence deductible		
Coinsurance	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	
Coinsurance Maximum ***Single*** ***Family***	**$2,000** **$4,000** (excludes deductibles)	**$4,000** **$8,000** (excludes deductibles)	**$2,000** **$4,000** (excludes deductibles)	**$4,000** **$8,000** (excludes deductibles)	
Physicians Office Visits	Chiropractic benefits limited to $500 a year, per person, after deductible No per-occurrence deductibles or copays Plan pays 80% You pay 20%	Plan pays 60% You pay 40%	**$10** per-visit deductible, then: Plan pays 80% You pay 20%	Plan pays 60% You pay 40%	
Prescription Drugs	Participating pharmacies and mail order only: You pay 100% of the plan's allowable cost until the annual deductible is met. Afterward, the plan will reimburse 80% of the allowable cost, you pay 20%. When coinsurance maximum is reached, the plan will reimburse 100% of the allowable cost.		Participating pharmacies only (up to 31-day supply): **$10** generic, **$25** preferred brand, **$40** non-preferred brand Mail order (up to 90-day supply): **$25** generic, **$62** preferred brand, **$100** non-preferred brand Copay max: **$2,500**		
Mental Health/ Substance Abuse	Participating providers only. Call 800-221-8699. Subject to above deductibles and coinsurance.		Participating providers only. Call 800-221-8699. Subject to above deductibles and coinsurance.		
Lifetime Maximum	**$1,000,000**		**$1,000,000**		

[1]If more than one family member is covered, no family member will receive benefits, other than preventive, until the
[2]There is no outpatient facility copay for services performed at a Medical University of South Carolina outpatient facility.
Please Note: *This chart is just a summary of your benefits. Please consult the Retirees and health plan chapters for details.*

and Dependents NOT Eligible for Medicare

	Traditional HMO		HMO with a Point of Service Option (POS)	
	All care must be directed by a primary care physician (PCP) and approved by the HMO.		To receive the higher level of benefits, care must be directed by a primary care physician (PCP) and approved by the HMO. Medically necessary benefits are available out-of-network at a lower benefit.	
	BlueChoice HealthPlan	**CIGNA HMO**	**MUSC Options**	
	Available in all counties in South Carolina	Available in all S.C. counties, **except**: *Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda*	Available in these S.C. counties: *Berkeley, Charleston, Colleton and Dorchester*	
	$250 **$500** (Does not apply to copays)	None	**In-network** None	**Out-of-network** **$300** **$900**
	Inpatient: **$200** copay Outpatient: **$75** copay/first 3 visits Emergency care: **$100** copay HMO pays 90% after copays and deductible You pay 10% **$35** Urgent care copay, then HMO pays 100%	Inpatient: **$500** copay Outpatient facility: **$250** copay Emergency care: **$100** copay	Inpatient: **$300** copay Outpatient facility: **$100**[2] copay Emergency care: **$100** copay **$35** Urgent care copay	HMO pays 60% after annual deductible You pay 40% No preventive care benefits out-of-network
	HMO pays 90% after deductible and copays You pay 10%	HMO pays 80% after copays You pay 20%	HMO pays 100% after copays	HMO pays 60% after deductible You pay 40%
	$1,500 **$3,000** (excludes deductibles)	**$3,000** **$6,000** (includes inpatient, outpatient, copays and coinsurance)	N/A	**$3,000** **$9,000** (excludes deductibles)
	$15 PCP copay **$15** OB/GYN well woman exam **$30** specialist copay	**$20** PCP copay **$40** OB/GYN exam **$40** specialist copay	**$15** PCP copay **$15** OB/GYN well woman exam - 2 per benefit period **$25** specialist copay with referral **$45** specialist copay without referral	HMO pays 60% of allowance after annual deductible You pay 40% No preventive care benefits out-of-network
	Participating pharmacies only (up to 31-day supply): **$8** generic, **$30** preferred brand, **$50** non-preferred brand, **$75** specialty pharmaceuticals Mail order (up to 90-day supply): **$16** generic, **$60** preferred brand, **$100** non-preferred brand	Participating pharmacies only (up to 31-day supply): **$7** generic, **$25** preferred brand, **$50** non-preferred brand Mail order (up to 90-day supply): **$14** generic, **$50** preferred brand, **$100** non-preferred brand	Participating pharmacies only (up to 31-day supply): **$10** generic, **$25** preferred brand, **$40** non-preferred brand Mail order (up to 90-day supply): **$15** generic, **$50** preferred brand; **$80** non-preferred brand	
	Participating providers only. Call 800-969-1032 Inpatient: **$200** copay, then 90% covered Outpatient: **$30** specialist copay	Participating providers only. Inpatient: **$500** copay, then 80% covered Outpatient: **$40** specialist copay	Inpatient: **$30** copay with referral, **$45** copay without referral	HMO pays 60% of allowance after annual deductible
	$1,000,000	**$1,000,000**	**$1,000,000**	

$6,000 annual family deductible is met.

Comparison of Health Plan Benefits for Retirees

Plan	SHP Savings Plan	SHP Standard Plan	
Inpatient Hospital Days[1]	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	
Skilled Nursing Care	Plan pays 80% You pay 20% up to **$6,000** or 60 days, whichever is less (Medi-Call required)	Plan pays 80% You pay 20% up to **$6,000** or 60 days, whichever is less (Medi-Call required)	
Private Duty Nursing	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	
Home Healthcare	**$5,000** or 100 visits, whichever is less, if Medi-Call approved.	**$5,000** or 100 visits, whichever is less, if Medi-Call approved.	
Hospice Care	**$6,000** lifetime maximum, including **$200** bereavement counseling	**$6,000** lifetime maximum, including **$200** bereavement counseling	
Durable Medical Equipment	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	
Routine Mammography Screening	Ages 35-74 in participating facilities only; guidelines apply	Ages 35-74 in participating facilities only; guidelines apply	
Pap Test	Ages 18-65 Routine or diagnostic	Ages 18-65 Routine or diagnostic	
Ambulance	Plan pays 80% You pay 20% with coinsurance maximum for emergency transport	Plan pays 80% You pay 20% with coinsurance maximum for emergency transport	
Eyeglasses/Hearing Aid	None, except for prosthetic lenses from cataract surgery. Discount under the Vision Care Program.	None, except for prosthetic lenses from cataract surgery. Discount under the Vision Care Program.	

[1]*Semi-private room and board, physician/surgeon charges, operating/delivery room and recovery room, general nursing*

and Dependents NOT Eligible for Medicare (cont.)

	BlueChoice HealthPlan HMO	CIGNA HMO	MUSC Options	
	Plan pays 90% You pay 10% with a **$200** copay and coinsurance	Plan pays 80% You pay 20% with **$500** copay and coinsurance maximum	**In-network** Plan pays 100% You pay **$300** copay	**Out-of-network** Plan pays 60% You pay 40% Subject to deductible
	Plan pays 90% You pay 10% up to 120 days	Plan pays 80% You pay 20% up to 180 days	Plan pays 100% up to $6,000 or 60 days, whichever is less, per benefit period	Plan pays 60% You pay 40% Subject to deductible
	Plan pays 90% You pay 10% up to 60 days	Plan pays 100%	Plan pays 100%	Covered in-network only
	Plan pays 90% You pay 10%	Plan pays 100% up to 60 visits	Plan pays 100% up to **$5,000** or 100 visits, whichever is less, per benefit period	Plan pays 60% You pay 40% Subject to deductible
	Plan pays 90% You pay 10%	Not included	Plan pays 100% **$6,000** lifetime maximum	Plan pays 60% You pay 40% Subject to deductible
	$5,000 maximum Plan pays 90% You pay 10%	**$3,500** maximum Plan pays 100%	Plan pays 100%	Covered in-network only
	Plan pays 100%; guidelines apply	Plan pays 100%	Plan pays 100%	Covered in-network only
	Routine: any age; 2 per year; **$15** copay Diagnostic: copay/coinsurance	Plan pays 100% You pay **$40** copay	Routine: any age; 2 per year; **$15** copay Diagnostic: copay/coinsurance	Covered in-network only
	Plan pays 90% You pay 10%	Plan pays 80% You pay 20%	Plan pays 100%	Plan pays 60% You pay 40% Subject to deductible
	One exam for glasses or contacts per year (**$45** copay for contacts exam). One pair glasses every other year (from designated selection)	One exam every two years (**$10** copay) Must use a participating provider	Plan pays up to **$75** for routine eye exam once per benefit period Plan pays up to **$75** for eyewear once every other benefit period	

and miscellaneous hospital services and supplies.

Comparison of Health Plan Benefits for Retirees

Type			PPO To receive a higher level of benefits, subscribers should choose an in-network provider.
Plan	**Medicare**	**Medicare Supplemental**	**SHP Standard Plan**
Availability	United States (Contact Medicare for information about any services outside of the United States)	Same as Medicare	Coverage Worldwide
Cancellation Policy	None	Cancelled upon request or for non-payment of premiums	Cancelled upon request or for non-payment of premiums
Annual Deductible	Part A: **$952** (per benefit period) Part B: **$124**	Pays Medicare Part A and Part B deductibles	**$350** (single) **$700** (family) Carve-out method applies
Per-occurrence Deductible	Inpatient hospital: Part A deductible (**$952** per benefit period)	Pays Medicare Part A deductible (Call Medi-Call for hospital stays over 150 days, skilled nursing, private duty nursing, home healthcare, durable medical equipment and VA hospital services)	Outpatient hospital: **$75** deductible Emergency care: **$125** deductible (Call Medi-Call for hospital stays over 150 days, skilled nursing, private duty nursing, home healthcare, durable medical equipment and VA hospital services)
Coinsurance	Part A: 100% Part B: 80% (You pay 20%)	Pays Part B coinsurance of 20%	Carve-out method applies Plan allows 80%
Coinsurance Maximum	None	None	**In-network** **$2,000** (single) **$4,000** (family) **Out-of-network** **$4,000** (single) **$8,000** (family) Excludes deductible
Physician Visits	Plan pays 80% You pay 20% Routine annual physicals and OB/GYN exams not covered	Plan pays Part B coinsurance of 20%	Carve-out method applies; **$10** per-occurrence deductible; Plan allows 80% in-network, 60% out-of-network Well Child Care visits and immunizations paid at 100% in-network through age 12.
Prescription Drugs	Covered under Medicare Part D. However, subscribers to health plans offered through the Employee Insurance Program have creditable coverage and therefore do not need to sign up for Part D.	Participating pharmacies only (up to 31-day supply): **$10** generic **$25** preferred brand **$40** non-preferred brand Mail-order (up to 90-day supply): **$25** generic **$62** preferred brand **$100** non-preferred brand Copay max: **$2,500**	Participating pharmacies only (up to 31-day supply): **$10** generic **$25** preferred brand **$40** non-preferred brand Mail-order (up to 90-day supply): **$25** generic **$62** preferred brand **$100** non-preferred brand Copay max: **$2,500**
Mental Health/ Substance Abuse	Inpatient: Plan pays 100% for days 1-60 (Part A deductible applies); You pay **$238**/day for days 61-90; You pay **$476**/day for days 91-150 (subject to 60 lifetime reserve days); You pay all cost after 150 days. Outpatient: Plan pays 50% (Part B deductible applies)	Inpatient: Plan pays Medicare deductible; **$238** coinsurance for days 61-90; **$476** coinsurance for days 90-150; 100% after 150 days (APS approval required). Outpatient: Plan pays Medicare deductible, 50% coinsurance	Carve-out method applies Plan allows 80% in-network (APS participating providers only if hospital stay exceeds 150 days)
Lifetime Maximum	**None**	**$1,000,000**	**$1,000,000**

and Dependents Eligible for Medicare

	Traditional HMO		HMO with a Point of Service Option (POS)	
	All care must be directed by a primary care physician (PCP) and approved by the HMO.		To receive the higher level of benefits, care must be directed by a primary care physician (PCP) and approved by the HMO. Medically necessary benefits are available out-of-network at a lower benefit.	
	BlueChoice HealthPlan HMO	**CIGNA HMO**	**MUSC Options**	
	Available in all South Carolina counties	Available in all S.C. counties, **except**: *Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda*	Available in the following S.C. counties: *Berkeley, Charleston, Colleton and Dorchester*	
	Cancelled upon request or for non-payment of premiums	Cancelled upon request or for non-payment of premiums	Cancelled upon request or for non-payment of premiums	
	Pays Medicare Part A and Part B deductibles	No deductible; Pays lesser of unreimbrused Medicare-allowed expenses or plan's normal allowance	Pays Medicare Part A and Part B deductibles	
	Pays Medicare Part A deductible	Inpatient: **$500** copay Outpatient facility: **$250** copay Emergency care: **$100** copay	Pays Medicare Part A deductible	
	Pays Part B coinsurance of 20%	Plan pays 80% or unreimbursed Medicare-allowed expenses.	Pays Part B coinsurance of 20%	
	None	**$3,000** (single) **$6,000** (family) (excludes certain copays)	**In-network** None	**Out-of-network** $3,000 (single) $9,000 (family) (excludes deductibles)
	Plan pays Part B coinsurance of 20%	**$20** PCP copay **$40** OB/GYN exam **$40** specialist copay Plan pays 80% or unreimbursed Medicare-allowed expenses	Plan pays Part B coinsurance of 20%	HMO pays 60% of allowance after annual deductible You pay 40% No preventive care benefits out-of-network
	Participating pharmacies only (up to 30-day supply): **$8** generic **$30** preferred brand **$50** non-preferred brand **$75** specialty pharmaceuticals Mail order (up to 90-day supply): **$16** generic **$60** preferred brand **$100** non-preferred brand	Participating pharmacies only (up to 30-day supply): **$7** generic **$25** preferred brand **$50** non-preferred brand Mail-order (up to 90-day supply): **$14** generic **$50** preferred brand **$100** non-preferred brand No copay max	Participating pharmacies only (up to 30-day supply): **$8** generic **$30** preferred brand **$50** non-preferred brand **$75** specialty pharmaceuticals Mail order (up to 90-day supply): **$16** generic **$60** preferred brand **$100** non-preferred brand	
	Inpatient: Plan pays Medicare deductible; **$238** coinsurance for days 61-90; **$476** coinsurance for days 91-150; 100% beyond 150 days Outpatient: Plan pays Medicare deductible, 50% coinsurance	Participating providers only: Inpatient: **$500** copay Outpatient: **$40** specialist copay Plan pays 80% or unreimbursed Medicare-allowed expenses	Inpatient: Plan pays Medicare deductible; **$228** coinsurance for days 61-90; **$456** coinsurance for days 91-150; 100% beyond 150 days Outpatient: Plan pays Medicare deductible, 50% coinsurance	
	$1,000,000	**$1,000,000**	**$1,000,000**	

Retirees

Comparison of Health Plan Benefits for Retirees

Plan	Medicare	Medicare Supplemental	SHP Standard Plan
Inpatient Hospital Days	Plan pays 100% for days 1-60 (Part A deductible applies); You pay **$238**/day for days 61-90; You pay **$476** for days 91-150 (subject to 60 lifetime reserve days); You pay all costs beyond 150 days	Plan pays: Medicare deductible; $238 coinsurance for days 61-90; $476 coinsurance for days 91-150; 100% beyond 150 days (Medi-Call approval required)	Carve-out method applies Plan allows 80% (Call Medi-Call if hospital stay exceeds 150 days)
Skilled Nursing Care	Plan pays 100% for days 1-20; You pay **$119** for days 21-100	Plan pays $119 for days 21-100; Plan pays 100% beyond 100 days (Medi-Call approval required) up to $6,000 or 60 days, whichever is less	Carve-out method applies Plan allows 80%, up to **$6,000** or 60 days, whichever is less. (Call Medi-Call if hospital stay exceeds 100 days)
Private Duty Nursing	Not covered	$200 annual deductible Plan pays 80% if Medi-Call approved You pay 20% $5,000 annual maximum $25,000 lifetime maximum	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call approval required)
Home Healthcare	Plan pays 100%	Medi-Call available to assist with referrals Up to $5,000 or 100 visits, whichever is less	Carve-out method applies Plan allows 80% You pay 20% up to **$5,000** or 100 visits, whichever is less
Hospice Care	Plan pays 100%	Medi-Call available to assist with referrals	Medi-Call available to assist with referrals
Durable Medical Equipment	Plan pays 80% (Medicare approval required) You pay 20%	Plan pays 20% coinsurance (Medi-Call required)	Carve-out method applies Plan allows 80% (Medi-Call approval required)
Routine Mammography Screening	Age 40 and older, one every year Plan pays 80% You pay 20%	Plan pays 20% coinsurance	Ages 35-74 in participating facilities only; guidelines apply
Pap Test	Routine every two years (yearly if high risk) Plan pays 100% for Pap test Plan pays 80% for exam	Plan pays 20% coinsurance. Otherwise, plan pays yearly for routine or diagnostic Pap tests for covered women ages 18-65. Diagnostic only age 66 and older.	Routine yearly ages 18-65; Diagnostic only age 66 and older; Plan allows 100% for Pap test (carve-out applies when Medicare pays)
Ambulance	Plan pays 80% You pay 20%	Plan pays 20% coinsurance	Carve-out method applies Plan allows 80%
Eyeglasses/ Hearing Aid	None, except for prosthetic lenses from cataract surgery. Discount under the Vision Care Program	None, except for prosthetic lenses from cataract surgery. Discount under the Vision Care Program	None, except for prosthetic lenses from cataract surgery. Discount under the Vision Care Program

Please note: *This chart is just a summary of your benefits. Please consult the Retiree and health plan chapters for details.*

and Dependents Eligible for Medicare (cont.)

BlueChoice HealthPlan HMO	CIGNA HMO	MUSC Options HMO
Plan pays: Medicare deductible; **$238** coinsurance for days 61-90; **$476** coinsurance for days 91-150; 100% beyond 150 days	Plan pays 80% or unreimbursed Medicare-allowed expenses after **$500** copay	Plan pays: Medicare deductible; **$238** coinsurance for days 61-90; **$476** coinsurance for days 91-150; 100% beyond 150 days
Plan pays **$119** for days 21-100; Plan pays 100% beyond 100 days (limited to 120 days)	Plan pays 80% or unreimbursed Medicare-allowed expenses, up to 180 days	Plan pays **$119** for days 21-100; Plan pays 100% beyond 100 days (limited to 120 days)
Plan pays 80%; You pay 20% and **$200** annual deductible **$5,000** annual maximum **$25,000** lifetime maximum (limited to 120 days)	Plan pays 100%	Plan pays 80%; You pay 20% and **$200** annual deductible **$5,000** annual maximum **$25,000** lifetime maximum (limited to 120 days)
(Medicare pays 100% of covered charges)	Plan pays 100% or unreimbursed Medicare-allowed expenses, up to 60 visits	(Medicare pays 100% of covered charges)
(Medicare pays 100% of covered charges)	Plan pays 100% or unreimbursed Medicare-allowed expenses	(Medicare pays 100% of covered charges)
Plan pays 20% coinsurance	**$3,500** maximum Plan pays 100% or unreimbursed Medicare-allowed expenses	Plan pays 20% coinsurance
Plan pays 20% coinsurance	Plan pays 100% or unreimbursed Medicare-allowed expenses	Plan pays 20% coinsurance
Plan pays 20% coinsurance. Otherwise, pays routine OB/GYN exam two times per year after **$15** copay. Diagnostic: copay/coinsurance	Plan pays 100% or unreimbursed Medicare-allowed expenses after **$25** copay	Plan pays 20% coinsurance. Otherwise, pays routine OB/GYN exam two times per year after **$15** copay. Diagnostic: copay/coinsurance
Plan pays 20% coinsurance	Plan pays 90% or unreimbursed Medicare-allowed expenses	Plan pays 20% coinsurance
One exam for glasses or contacts per year (**$45** copay for contacts exam). One pair of glasses every other year (from designated selection)	One exam every two years (**$10** copay) Must use a participating provider	One exam for glasses or contacts per year (**$45** copay for contacts exam). One pair of glasses every other year (from designated selection)